

ENDO-MED CLINIC, S.C.

PATIENT INFORMATION

PLEASE PRINT

All information must be filled out in full

Today's date:				PCP:	
Patient's last name:		First:	Middle:	Marital status (circle one) ***	
				Single / Mar / Div / Sep / Wid	
Birth date:	Age:	Sex: M F	Is this patient a minor? Yes No If yes please fill out parents information.		
Street address:			Home phone no.: ()		
City:			State:	ZIP Code:	
SSN:			Cell Phone no.:		
Please fill out the information below if patient is a minor					
Patient's Mother's Info		Birth date:	Address (if different):		Home phone no.:
		/ /			Cell Phone no.:
Employer:				Social Security #	
Employer Address:				Employer phone no.:()	
Patient's Father's Info		Birth date:	Address (if different):		Home phone no.:
		/ /			Cell Phone no.:
Employer:				Social Security #	
Employer Address:				Employer phone no.:()	

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Please note: In cases of divorce, it is our policy that responsibility of any amount left owed after insurance has paid will be the responsibility of the parent who brings the child for their appointments.

Primary Insurance Name					
Subscriber's name:	Subscriber's S.I. no.:	DOB	Group #:	Policy no.:	Co-payment:
		/ /			\$
Employer:	Address:			Phone:	
Patient's relationship to subscriber:	☐ Self	☐ Spouse	☐ Child	☐ Other	
Secondary Insurance Carrier					
Subscriber's name:	Subscriber's S.I. no.:	DOB	Group #:	Policy no.:	Co-payment:
		/ /			\$
Employer:	Address:			Phone:	
Patient's relationship to subscriber:	☐ Self	☐ Spouse	☐ Child	☐ Other	

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.:	Work phone no.:
		()	()

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I authorize Joliet Doctors Clinic SC or insurance company to release any information required to process my claims. I accept responsibility for any fees in absence of insurance. I also accept to pay all co-payments and coinsurance at the time the service is rendered.

Patient/Guardian signature

Date

ENDO-MED CLINIC, S.C.
PATIENT PAST SURGICAL HISTORY

WHAT IS YOUR OCCUPATION: _____

(PLEASE CHECK ALL THAT APPLY):

DO YOU SMOKE:	___ YES	___ NO
DO YOU DRINK ALCOHOL:	___ YES	___ NO

SURGICAL HISTORY:

NO SURGERY	___	HYSTERECTOMY	___
AMPUTATION	___	KNEE ARTHROSCOPY	___
APPENDECTOMY	___	LAPAROSCOPY	___
BREAST BIOPSY	___	LUMPECTOMY	___
CARDIAC PACEMAKER	___	MASTECTOMY	___
CARDIAC SURGERY	___	ORAL SURGERY	___
CARPAL TUNNEL RELEASE	___	OVARIAN CYSTECTOMY	___
CERVICAL CONE BIOPSY	___	SPINE SURGERY	___
CESAREAN SECTION	___	SPLENECTOMY	___
COLOSTOMY	___	TONSILLECTOMY	___
ENDOMETRIAL ABLATION	___	TONSILS AND ADENOIDS	___
GALL BLADDER	___	THYROIDECTOMY	___
HEMORRHOIDECTOMY	___	TUBAL LIGATION	___
HYSTERECTOMY	___		
OTHER			

ENDO-MED CLINIC, S.C.
PATIENT MEDICAL HISTORY

HAVE YOU OR YOUR FAMILY EVER HAD: (PLEASE CHECK ALL THAT APPLY)

<u>DISEASE/DISORDER</u>	<u>YOU</u>	<u>FAMILY</u>	<u>DISEASE/DISORDER</u>	<u>YOU</u>	<u>FAMILY</u>
ANEMIA	_____	_____	HEMORRHOIDS	_____	_____
ANEURYSM	_____	_____	HEPATITIS	_____	_____
ARTHRITIS	_____	_____	HERNIA	_____	_____
ARTRIAL FIBRILATION	_____	_____	HERNIATED DISC	_____	_____
ASTHMA	_____	_____	HIV POSTIVE	_____	_____
BIPOLAR DISORDER	_____	_____	HYPERCHOLESTEROLAMIA	_____	_____
BRONCHITIS	_____	_____	HYPERTENTION	_____	_____
CANCER	_____	_____	HYPERTHYROIDISM	_____	_____
CARDIOMYAPATHY	_____	_____	HYPOTHYROIDISM	_____	_____
CARPAL TUNNEL SYNDROME	_____	_____	KIDNEY FAILURE	_____	_____
CATARACTS	_____	_____	KIDNEY STONES	_____	_____
CHRON'S DISEASE	_____	_____	LIVER FAILURE	_____	_____
CHRONIC LUNG DISEASE	_____	_____	LUPUS	_____	_____
CIRRHOSIS	_____	_____	MACULAR DEGENERATION	_____	_____
COLITIS	_____	_____	MITRAL VALVE PROLAPSE	_____	_____
CONGENITAL HEART DISEASE	_____	_____	MRSA POSITIVE	_____	_____
CONGESTIVE HEART DISEASE	_____	_____	MULTIPLE SCLEROSIS	_____	_____
CORONARY ARTER DISEASE	_____	_____	OSTEOPOROSIS	_____	_____
DEMENTIA	_____	_____	PANCREATITIS	_____	_____
DEPRESSION	_____	_____	PARKINSONS DISEASE	_____	_____
DIABETES	_____	_____	PNEUMONIA	_____	_____
DIVERTICULOSIS	_____	_____	PULMONARY EMBOLISM	_____	_____
DIZZINESS	_____	_____	SCHIZOPHRENIA	_____	_____
EAR INFECTIONS	_____	_____	SEIZURES	_____	_____
EMPHYSEMA	_____	_____	SICKLE CELL ANEMIA	_____	_____
ENDOMETRIOSIS	_____	_____	STDS	_____	_____
FIBROMYALGIA	_____	_____	THROMBOSIS	_____	_____
GERD	_____	_____	TUBERCULOSIS	_____	_____
GLAUCOMA	_____	_____	ULCERS	_____	_____
GOUT	_____	_____	URINARY TRACT INFECTION	_____	_____
HEADACHES	_____	_____	UTERINE FIBROIDS	_____	_____
			VARICOSE VEINS	_____	_____

PATIENT CONSENT FORM
ENDO-MED CLINIC S.C.
3033 W. JEFFERSON ST
SUITE 206
JOLIET IL 60435

I understand that under the health insurance portability and accountability act of 1996 (HIPAA) I have certain rights to privacy regarding my health information. I understand that the information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physicians certifications.

I have been informed by you of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I contact this organization any time at the address below to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used and disclosed to carry out treatment, payment or health care operations. I also understand that you are required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

PATIENT NAME: _____

SIGNATURE: _____

RELATIONSHIP TO PATIENT: _____

DATE: _____

ENDO-MED CLINIC, S.C.
3033 W. Jefferson St
Suite 206
Joliet IL 60435

Narcotic Medication Policy:

In order to help protect you as a patient and End-Med Clinic as a practice please take a moment and read our policy for narcotic medication.

All narcotic medication prescriptions will only be faxed from End-Med Clinic to one predetermined pharmacy of your choice, we will no longer hand the prescription to the patient. Please remember that you may only use one pharmacy for all narcotic medications. All other maintenance medications will be at your discretion.

Print Name _____

Signature _____

Date _____

Pharmacy Name _____

Pharmacy Location _____

Pharmacy Number _____

ENDO-MED CLINIC, S.C.
3033 W. Jefferson St.
Suite 206
Joliet, IL 60435
815/730-3304

Endo-Med Clinic will charge \$50.00 for a missed appointment. If you find that you will not be able to keep your appointment, it is imperative that you call the office **24 hours** in advance to cancel or reschedule your appointment. If the appointment has not been cancelled prior to the 24 hour notice, you will be charged for a **No Show Appointment**. Thank you for your continued support of Endo-Med Clinic, S.C.

Patient Signature

Date

ENDO-MED CLINIC
TRIAGE INFORMATION SHEET

When Endo-Med Clinic calls to report test results and the patient is not available we need the patient's permission to leave a message as instructed below:

- 1. Can we leave a detailed message on answering machine or voicemail:**

YES NO

- 2. Please list all the people we can leave message with, please include phone number and relationship to patient:**

- 3. We can contact you at:**

Home: _____

Cell: _____

Work: _____

- 4. Pharmacy Name, Location, Phone number:** _____

Print Name: _____

Date: _____

Signature: _____

Endo-Med Clinic S.C.

3033 W Jefferson St

Suite 206

Joliet, IL 60435

It is the responsibility of the patient to call ahead to make sure the physicians at Endo-Med Clinic S.C. are within the network of their insurance. In the case that the insurance does not pay because we are out-of-network or the physician is not covered by the insurance company, it is the patient's responsibility to pay the bill

Thank You,

Endo-Med Clinic SC

Signature _____ Date _____